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Supreme Court, U.S.
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No. _____

In the Supreme Court of the United States

NANCY DICKENSON, CONSERVATOR
FOR SANDRA ROBINSON,

Petitioner,

v.

CARDIAC AND THORACIC SURGERY OF
EASTERN TENNESSEE, P.C.,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Did the Sixth Circuit err in upholding the Magistrate's decision to grant summary judgment in favor of the Respondent, Cardiac & Thoracic?

2. Did the Sixth Circuit err in finding that Dr. W. Dudley Johnson was not qualified to give an opinion on whether the Respondent deviated from the standard of care?

3. Did the Sixth Circuit err in its analysis under FRE 702 and *Daubert*?

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

The parties to this proceeding are set forth in the case caption. Petitioner is a practicing attorney in Virginia who has been appointed to serve as a Limited Conservator for Sandra Robinson. Neither Dickenson nor Robinson is a subsidiary or affiliate of a publicly owned corporation. Upon information and belief, the Respondent is not a subsidiary or affiliate of a publicly owned corporation.

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The Sixth Circuit rendered its opinion on October 25, 2004 and is reprinted at App. A, 1-15 . The Magistrate's Opinion from the Eastern District of Tennessee is reprinted at App. B, 16-21. It is not a reported decision.

STATEMENT OF JURISDICTION

The Sixth Circuit rendered its opinion on October 25, 2004. This Petition for Writ of Certiorari is timely in that it is filed within 90 days of October 25, 2004. This Court has jurisdiction pursuant to 28 §1254 (1).

STATUTORY PROVISIONS INVOLVED

Some of the issues that are involved in this Petition may relate to the following statute:

Tennessee Code § 29-26-115.

(a) In a malpractice action, the claimant shall have the burden of proving by evidence as provided by subsection (b):

> (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred...

STATEMENT OF THE CASE

A. Prior Proceedings

Sandra Robinson ["Sandra" or "Robinson"] was catastrophically injured as a result of medical treatment in November 1998. She filed a civil action alleging medical negligence against Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. ["Cardiac & Thoracic"], and others, in November 2000 in the United States District Court for the Eastern District of Tennessee. The district court had original jurisdiction of this action pursuant to the provisions of 28 U.S.C. § 1343, due to the diversity of citizenship between the parties.

In January 2003, Cardiac & Thoracic and Robert Rosser, a co-defendant, moved for Summary Judgment. Cardiac & Thoracic attached to its Motion the Affidavits of five local physicians. Robinson opposed the Motion of Cardiac & Thoracic, and responded by submitting the Affidavit of Dr. W. Dudley Johnson, Johnson's 26 (a) (2) Report and his entire discovery deposition.

On March 5, 2003, the Magistrate granted Cardiac & Thoracic's Motion for Summary Judgment and the co-defendant's [Rosser's] similar Motion [App B at 16-21].

Counsel for Robinson timely filed her Notice of Appeal to the Sixth Circuit Court of Appeals on March 13, 2003. The Sixth Circuit Court of Appeals had jurisdiction to consider the issues on appeal pursuant to 28 U.S.C. § 1291. The Sixth Circuit reversed the Magistrate as to Rosser, finding that Dr. Johnson was qualified to give opinions under FRE 702, but yet affirmed the Magistrate as to Cardiac & Thoracic, finding that Dr. Johnson was not qualified to give opinions.

B. Statement of Facts

The medical records pertaining to the care and treatment of Robinson are recited in detail in the Expert Report of Dr. W. Dudley Johnson. The details of his review are contained in the FRCP 26(a) (2) Report. Attached to his report is his *Curriculum Vitae*.

The medical records establish the following facts. On November 10, 1998, Dr. Michalik, who was an agent of Cardiac & Thoracic, performed myocardial revascularization times four, also known as "by-pass surgery". Throughout Robinson's care, Arterial Blood Gases [ABGs] were ordered. These studies give a reliable picture of a patient's ability to breathe on her own. These values are important in any assessment of the patient's ability to self-ventilate, and have particular significance to the decision to extubate a patient. Prior to surgery, Robinson's values were within normal limits. Following surgery, Dr. Michalik ordered Morphine to be given. Throughout the evening and continuing into the next morning, significant dosages of morphine were administered. The administration of morphine in these quantities was significant because of the propensity for morphine to cause respiratory depression. In total, Sandra Robinson was administered 80 mg of morphine between 6:00 p.m. on November 10th and 8:15 a.m. on November 11th. Without the aide of a ventilator, Robinson would certainly have gone into respiratory arrest. Morphine is a well known narcotic and sedative with warnings of respiratory depression. Dr. Johnson opined that the respiratory depressive attributes of the drug were not appropriately recognized by either Dr. Rosser, who was the attending pulmonologist, and Dr. Michalik at the time extubation was ordered.

A portable chest x-ray showed "hazy opacity of the lungs". A later chest X-ray status showed "diffuse hazy opacity in the lungs consistent with shallow inspiration or early air space disease". Dr. Johnson opined that these x-rays demonstrated that Sandra's ability to breathe was getting worse and was another factor that would weigh against extubation.

On the morning of November 11, 1998, the ABG studies that were taken prior to extubation confirmed that Sandra was significantly under ventilated at the moment she was extubated. The under-ventilation is explained by the large amounts of narcotic being administered. Dr. Rosser ordered ABGs to be drawn after extubation. They remained abnormally low. Robinson remained significantly under-ventilated throughout the day. Dr. Johnson opined that Robinson should not have been extubated while she was in this condition, and the negligent decision to extubate should have been immediately corrected by both Dr. Michalik and Dr. Rosser.

Later in the evening of November 11th, other medications were administered that have well recognized propensities to cause respiratory depression. With someone who was in a condition of underventilation and in respiratory depression, these medications will have a tendency to exacerbate the respiratory condition of the patient. Dr. Johnson opined that this is exactly the scenario that unfolded with Sandra Robinson on the evening of November 11, 1998. At 10:05 p.m. on November 11, 1998, Robinson's ABG Values remain abnormally low. Her oxygen saturations dropped significantly. It is a recognized medical fact that one of the expected consequences of respiratory depression is reduced oxygen to the body, and in particular to the brain. For Robinson, the oxygen desaturations produced irreversible

brain damage in the form of an anoxic/hypoxic brain injury. This serious consequence was part of the rationale for not extubating Robinson while she was in respiratory depression. Once the desaturations began, the mechanism of injury occurred despite the best efforts of the medical community. Dr. Johnson opined that Sandra's injury was caused by the negligence of both Dr. Rosser and Dr. Michalik. Dr. Johnson opined that both the treating cardiac surgeon, Dr. Michalik, and the consulting pulmonologist, Dr. Rosser, must share in the responsibility to manage the patient's respiratory function. He opined that the cardiac surgeon was required to participate in the decision process and that he was required to correct any negligent decision to extubate the patient. Dr. Johnson opined that Robinson was not able to recover from the inappropriate decision to extubate, and the injury she sustained was permanent.

Based upon this Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993), the Magistrate concluded that Dr. Johnson was not qualified to give medical opinions as an expert. The Sixth Circuit affirmed this decision with respect to Dr. Michalik.

REASONS FOR GRANTING THE PETITION

Supreme Court Rule 10 identifies considerations used by the Court in deciding whether to exercise its discretion to grant a petition for writ of certiorari. One consideration is that a "United States court of appeals has decided an important question of federal law . . . that conflicts with relevant decisions of this Court." Another consideration is that a "United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter. . . ." Finally, the Court

considers whether the court of appeals decision "has so far departed from the accepted and usual course of judicial proceedings. . . as to call for an exercise of this Court's supervisory power . . . ."

As discussed in detail *infra*, all of these considerations are present in this case, and this Court's review is warranted for those reasons. The analysis employed by the Magistrate and upheld by the Sixth Circuit in ruling upon the Motions for Summary Judgment is critically flawed and is inconsistent with this Court's decisions relating to FRCP 56 Motions, and inconsistent with other Circuits. First, the Magistrate improperly credited disputed facts in favor of the Defendant in derogation of well established principles announced by this Court and followed by all other Circuit Courts of Appeal. Second, the Sixth Circuit upheld the Magistrate who engaged in making credibility assessments in the guise of exercising his "gatekeeping" function under *Daubert* in derogation of this Court's opinions. Third, the Sixth Circuit misinterpreted and misapplied the analysis required under FRE 702 and *Daubert*. Fourth, the Sixth Circuit's Opinion with respect to Cardiac & Thoracic is antagonistic with its own decision to permit Dr. Johnson to testify against the co-defendant, Dr. Rosser.

I. Review Is Warranted Because the Sixth Circuit's Decision Is in Direct Conflcit with Well Recognized Principles Related to FRCP 56 Motions

In ruling upon a FRCP 56 Motion, neither the district Magistrate nor the Sixth Circuit is empowered to find facts in the sense of resolving questions of credibility on conflicting testimony or affidavits. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-52, 106 S. Ct. 2505, 2510-12 (1986); *Plott v. General Motors Corp*, 71 F. 3d 1190 (6th Cir. 1995). Any objective review of this matter reveals that the exclusion of

Dr. Johnson's opinions is the result of crediting other expert opinions and discrediting Dr. Johnson's opinions, a practice expressly prohibited by FRCP 56 and this Court's precedent.

In *Anderson v. Liberty Lobby, Inc.*, this Court defined the context in which summary judgment would be granted.

> Our holding . . . does not denigrate the role of the jury. **It by no means authorizes trial on affidavits. Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, . . . [T]he evidence of the nonmovant is to be believed, and all justifiable inferences are to be drawn in his favor.** Neither do we suggest that trial courts should act other than with caution in granting summary judgment or that the trial courts may not deny summary judgment in a case where there is reason to believe that the better course would be to proceed to a full trial.

Id. at 255 (emphasis added); see also *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 456, 112 S.Ct. 2072, 2076 (1992); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157-59, 90 S.Ct. 1598, 1608-09 (1970).

Exclusion of expert testimony during the summary judgment stage is "particularly perplexing". *See Cortes-Irizarry v. Corporation Insular*, 111 F.3d 184 (1st Cir. 1997). In *Cortes-Irizarry,* the First Circuit stated:

> A trial setting normally will provide the best operating environment for the triage which *Daubert* demands. *Voir dire* is an extremely helpful device in evaluating proffered expert testimony, and this device is not

> readily available in the course of summary judgment proceedings. **Moreover, given the complex factual inquiry required by *Daubert*, courts will be hard-pressed in all but the most clear-cut cases to gauge the reliability of expert proof on a truncated record.** Because the summary judgment process does not conform well to the discipline that *Daubert* imposes, the *Daubert* regime should be employed only with great care and circumspection at the summary judgment stage. We conclude, therefore, that at the junction where *Daubert* intersects with summary judgment practice, *Daubert* is accessible, but courts must be cautious - except when defects are obvious on the face of a proffer - not to exclude debatable scientific evidence without affording the proponent of the evidence adequate opportunity to defend its admissibility.

Cortes-Irizarry, 111 F.3d at 190 (emphasis added).

In the Motion for Summary Judgment filed by Cardiac & Thoracic, Counsel advanced only two points: (1) Dr. Johnson did not demonstrate that he was familiar with the standard of care in Kingsport, Tennessee and (2) Dr. Rosser was not an agent of Michalik. Cardiac & Thoracic never suggested that Dr. Johnson's opinions should be excluded under *Daubert*. However, both the Magistrate and the Sixth Circuit excluded the opinions of Dr. Johnson as to Cardiac & Thoracic based upon a purported analysis under FRE 702 and *Daubert*.

Cardiac & Thoracic urged the Magistrate and the Sixth Circuit to discredit Dr. Johnson's opinions because Dr. Johnson's testimony to the effect that he knew the standard of care differed from the experts retained by Cardiac & Thoracic, and since the defense experts were from the local

area, they must be believed over the out of town doctor. Neither the Magistrate nor the appellate Courts are free to determine which expert is "more believable" from a review of affidavits in ruling upon a FRCP 56 Motion, and then exclude the perceived less credible expert under FRE 702.

In response to the assertions that Dr. Johnson is unfamiliar with the standard of care, Counsel for Robinson submitted a detailed Affidavit explaining his knowledge of the standard of care, as required by T.C.A. § 29-26-115. The Sixth Circuit is mistaken when it concludes that Dr. Johnson's knowledge related to the standard of care in Kingsport, Tennessee is based exclusively upon his reading of Dr. Michalik's deposition. To the contrary, his basis of this knowledge emanates from multiple sources: (1) A review of the published literature that explains the medical community; (2) A review of the published information that describes the community in general; (3) His personal knowledge and experience with the type of cardiac surgery being performed and the management of the patient post operatively; (4) Selected portions of the testimony of Dr. Rosser and Dr. Michalik contained in their depositions wherein they describe the standard of care and their educational background and training; (5) The medical records of Sandra Robinson; (6) CME classes where similar issues are discussed with physicians from Tennessee; and (7) Discussions with colleagues who practice in Tennessee.

On appeal, the Sixth Circuit addressed the exclusion of Dr. Johnson's testimony against both the pulmonologist and the cardiac surgeon. Its rationale for reversing the Magistrate's decision as to Dr. Rosser and affirming the Magistrate's decision as to Cardiac & Thoracic is the following (emphasis added):

Despite Dr. Johnson's extensive experience, the district court did not allow him to testify regarding the medical services rendered by Dr. Rosser on the ground that Dr. Johnson's testimony was unreliable under the gatekeeping principles set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786 (1993), and its progeny...
The district court appears to have relied most heavily upon its supposition that a "purported expert must demonstrate a familiarity with accepted medical literature or published standards in these other areas of specialization in order for his testimony to be reliable in the sense contemplated by Federal Rule of Evidence 702." This is an erroneous statement of the law. No authority was cited by the district court in support of its above-quoted statement regarding Rule 702, nor have we found any. In fact, "the text of Rule 702 expressly contemplates that an expert may be qualified on the basis of experience." Fed. R. Evid. 702 advisory committee's note (2000 Amendments) (emphasis added); see also *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 156, 143 L. Ed. 2d 238, 119 S. Ct. 1167 (1999) ("No one denies that an expert might draw a conclusion from a set of observations based on extensive and specialized experience."); *Amorgianos v. AMTRAK*, 303 F.3d 256, 267 (2d Cir. 2002) ("Where an expert otherwise reliably utilizes scientific methods to reach a conclusion, lack of textual support may go to the weight, not the admissibility of the expert's testimony.") (quotation marks omitted); *Bonner v. ISP Techs., Inc.*, 259 F.3d 924, 929 (8th Cir. 2001) ("There is no requirement that a medical expert must always cite published studies on general causation in order to reliably conclude that a particular object caused a particular illness.")...

> *Daubert*'s role of "ensuring that the courtroom door remains closed to junk science," *Amorgianos v. AMTRAK,* 303 F.3d 256, 267 (2d Cir. 2002), is not served by excluding testimony such as Dr. Johnson's that is supported by extensive relevant experience. Such exclusion is rarely justified in cases involving medical experts as opposed to supposed experts in the area of product liability. *See generally* Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. Health Pol. Pol'y & L. 267 (2001) (characterizing the effect of the *Daubert* and *Kumho Tire* cases on claims of medical expertise as "much ado about little," while noting that these cases have had a significant effect on toxic tort and products liability litigation). **We therefore conclude that the district court abused its discretion by excluding Dr. Johnson's testimony regarding the medical services rendered by Dr. Rosser**...

Thus, it is clear that the Sixth Circuit found that Dr. Johnson's opinions meet the requirements for admissibility under *Daubert* and FRE 702. Then, paradoxically, the Sixth Circuit refuses to allow Dr. Johnson to offer opinions as to Dr. Michalik because Dr. Johnson is not reliable under *Daubert* and FRE 702. Their explanation is as follows:

> As the district court noted, "Dr. Johnson professed that he relied upon the deposition testimony of Drs. Michalik and Rosser to underpin his knowledge of the standard of care applicable to cardiac surgeons[such as Dr. Michalik] in Kingsport, Tennessee." Nothing in those depositions, however, supports Dr. Johnson's opinion that the cardiac surgeon is responsible for the pulmonologist's decision of when to extubate a patient.

> At most, the deposition of Dr. Michalik indicates that the cardiac surgeon often makes the decision to extubate and that frequently such decisions are made collaboratively with a pulmonologist. In this case, however, the uncontroverted evidence establishes that Dr. Michalik called upon Dr. Rosser to "assume that responsibility" and "it was Dr. Rosser who ordered the extubation of the tube." The lack of support for Dr. Johnson's opinion, coupled with the affidavits of five Kingsport, Tennessee physicians who explained that the practice in Kingsport is that "once a pulmonology consult is obtained, the pulmonologist assumes management of the patient's ventilation and extubation," convinced the district court that Dr. Johnson's opinion on this issue was unreliable. In light of the lack of support for Dr. Johnson's opinion and the contrary evidence found in the affidavits of the local physicians, we conclude that the district court did not abuse its discretion by excluding this testimony. *See Kumho Tire Co., Ltd. v. Carmichael,* 526 U.S. 137, 152, 143 L. Ed. 2d 238, 119 S. Ct. 1167 (1999) ("The trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable.").

Dickenson v Cardiac & Thoracic, Slip Opinion @ 14-15.

The analysis used by the Sixth Circuit to conclude that Dr. Johnson opinions are unreliable as to Cardiac & Thoracic is clearly inconsistent with this Court's precedent in applying FRCP 56. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-52, 106 S. Ct. 2505, 2510-12 (1986) and its progeny. Dr. Johnson explained that he was intimately familiar with the type of surgery performed on Sandra Robinson as well as the

requirements for her post-surgical care, which included respiratory management. He has been involved in performing this exact surgery on hundreds of patients similar to Sandra. His experience with this surgery and the post operative respiratory management spans decades. He is involved with extubation decisions on a daily basis. In response to this thorough explanation, the Sixth Circuit concludes that he is not familiar with the standard of care because other physicians offer a different perspective. Under well established principles of FRCP 56 practice, it was clear error to ignore Dr. Johnson's statements as to familiarity with the standard of care, or to give no credence to them. Neither the Magistrate nor the Sixth Circuit is allowed to make that credibility determination in addressing a FRCP 56 Motion.

In rejecting Dr. Johnson's opinions, the Sixth Circuit never considered that T.C.A. § 29-26-115 (a) permits an expert to give opinions on the standard of care under two independent basis: (1) because he/she is familiar with the standard of care in the particular community, **or**, (2) because he/she is familiar with the standard of care in a similar community. *See Sandlin v. University Medical Center,* 2002 WL 1677716 (Tenn. Ct. App. 2002); *Roberts v. Bicknell*, 73 S.W.3d 106 (Tenn. Ct. App. 2001). If the proffered expert is familiar with either the standard of care in the community, or another community which is substantially similar to the Tennessee community, then he is deemed to be "competent" to testify. TCA §29-26-115. As stated in Dr. Johnson's Affidavit, the standard of care in Milwaukee, Wisconsin is identical to Kingsport, Tennessee. Thus, Dr. Johnson is entitled to testify that Dr. Michalik was negligent in spite of the conclusions submitted by the local physicians because Milwaukee, Wisconsin is substantially similar to Kingsport, Tennessee, in so far as the standard of medical care is concerned.

In order to affirm the exclusion of Dr. Johnson's opinions, the Sixth Circuit disregarded the evidence contained in Dr. Johnson's Affidavit, as well as reasonable inferences from the medical records. The medical records reveal that Dr. Michalik continued to be involved in the care and treatment of Sandra throughout her hospitalization, including November 11th. His responsibility for Sandra did not terminate upon his request for a pulmonary consult. FRCP 56 requires the Sixth Circuit to accept the evidence of the non-moving party as being true. *Eastman Kodak Co. v. Image Technical Servs., Inc., supra.* Dr. Johnson's opinions about Michalik are premised on the "joint responsibility" of Michalik and Rosser to see that extubation occurred at the proper time, and that negligent decisions be corrected. Michalik did not leave town after the surgery. He remained Sandra's primary physician. He attended to her on November 11, 1998, and issued orders relating to her care on November 11, 1998. Dr. Johnson opined that the standard of care requires Michalik to be part of the decision making process and to re-intubate her after Rosser negligently ordered her extubation. The Sixth Circuit is not permitted to accept the opinions of the proffered experts of Cardiac & Thoracic while giving no credence to Dr. Johnson.

II. Review Is Warranted Because the Sixth Circuit's Decision Is in Direct Conflcit with this Court's Decisions Interpreting Fre 702

The Sixth Circuit erred in its legal analysis of FRE 702 and *Daubert*. In *Daubert,* this Court rejected the restrictive *Frye* test of admissibility of expert opinions. "A rigid 'general acceptance' requirement would be at odds with the **'liberal thrust' of the Federal Rules** and their **'general approach of relaxing the traditional barriers to 'opinion' testimony"**. *Daubert* at 588 (emphasis added). "Vigorous cross-

examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." *Daubert,* 509 U.S. at 595. The purpose of a *Daubert* analysis is to "ensure that the courtroom remains closed to junk science..." *Amorgianos v. AMTRAK,* 303 F. 2d 256, 267 (2d Cir. 2002).

The analysis required by *Daubert* is to determine if the expert testimony is (1) relevant and (2) reliable. The Sixth Circuit must determine whether the Magistrate "clearly erred" in that application. As explained *supra*, the Sixth Circuit found that the Magistrate clearly erred in its interpretation of *Daubert*. In addressing *Daubert* type objections at the trial stage, the trial court must make "a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue." *Daubert* at 592-593. *See Benedi v. McNeil-P.P.C., Inc.* 66 F. 3d 1375, 1384 (4th Cir. 1995)(The test for admissibility after *Daubert* is determined by "the methodology employed by the expert in reaching his or her conclusion" and whether this methodology "is sound.").

In *United States v. 14.38 Acres of Land Situated in Leflore County, Miss.,* 80 F.3d 1074 (5th Cir. 1996), an eminent domain action, the landowner proffered an engineering expert and a real estate appraisal expert. The Trial Court excluded the experts' opinions. On appeal, the Fifth Circuit found that the exclusion of this testimony was error and an abuse of discretion, because the Trial Judge "applied too stringent a reliability test." *Daubert* had not worked a "seachange over federal evidence law" and the "the trial court's role as gatekeeper is not intended to serve as a replacement for the adversary system." *Id.*

A. Methodology

The appropriate *Daubert* analysis was to examine Dr. Johnson's methodology in arriving at his opinions. On the one hand, the Sixth Circuit found his methodology reliable and thus reversed the Magistrate, while on the other hand, found that he was not reliable to express an opinion as to the negligence of Dr. Michalik. However, both the Sixth Circuit and Magistrate failed to analyze Dr. Johnson's methodology, which is required under *Daubert*. Had either done so, it is clear that Dr. Johnson is entitled to offer his opinions as to the negligence of Dr. Michalik.

Dr. Johnson's methodology is as follows: (1) a meticulous review of the medical records and (2) application of his education, training and experience to the facts surrounding the care of the patient. Interestingly, every defense expert who explained his methodology, and not all of them did, employed the exact same methodology as Dr. Johnson. Counsel for Cardiac & Thoracic has never articulated any other methodology that should have been employed, and for obvious reasons, there is no other accepted methodology. Dr. Johnson's meticulous review of the medical records amply demonstrates that this methodology was followed.

There is nothing in the cases cited since *Daubert* or prior to *Daubert* that would indicate that testimony in a medical negligence case on the issue of whether there has been a breach of the standard of care should be excluded when the proffered expert reviews the pertinent medical records and analyzes those records within the field of his/her expertise. A lifetime of expert practice and experience is sufficient to qualify a physician to render an expert opinion. *Carroll v. Morgan*, 17 F.3d 787 (5th Cir. 1994). The Advisory Committee Notes to FRE 702 state "...the text of Rule 702

expressly contemplates that an expert may be qualified on the basis of experience. **In certain fields, experience is the predominant, if not sole, basis for a great deal of reliable expert testimony....[R]ejection of expert testimony is the exception rather than the rule"** *See* FRE 702 Advisory Committee Notes (emphasis added).

B. Qualifications of Dr. Johnson

Dr. Johnson's medical training, education, experience and qualifications are impressive. He obtained his medical degree from the University of Illinois Medical School in 1955. He did his rotating internship at Cook County Hospital, Chicago, IL from 1955 to 1957. He did a general surgical residency in Milwaukee, Wisconsin from 1959 through 1963, and a Thoracic-Cardiovascular Residency at Marquette Affiliated Hospitals, Milwaukee, WI from 1963 through 1965. He is a licensed Medical Doctor. He is a member of the American Board of Surgery and the American Board of Thoracic Surgery, which are national certifications. He has taught cardiac surgery at Marquette University School of Medicine and the Medical College of Wisconsin, and is currently teaching cardiac surgery. He has privileges at hospitals in the Milwaukee community. He is a member of the American Heart Association and the Council of Cardiovascular Surgery. He has served as a member of the State of Wisconsin Medical Examining Board where he evaluated physicians for licensure. He has been the recipient of the following awards: (1) The Medical Society of Milwaukee County 1991 Distinguished Service Award; (2) The American Association for World Health 1992 National World Health Day Award for Outstanding Contribution to the Prevention of Cardiovascular Disease and Commitment to World Health; (3) The Society of Thoracic Surgeons 2001 Earl Bakken Scientific Achievement Award for Outstanding Contribution to the Practice of

Cardiothoracic Surgery and (4) The Medical College of Wisconsin Honorary Award for the Recognition and Appreciation of Contributions to the Science of Heart Surgery. Dr. Johnson has been a pioneer in the development of cardiac arterial bypass surgery [CABG]. He has been authoring and co-authoring peer review articles in the field of cardiac surgery since 1966. These articles have been published in medical journals that are considered authoritative in the field of cardiac surgery. He has personally performed nearly ten thousand cardiac operations. He has operated in eight foreign countries. Patients have come to him for surgery from thirty-five foreign countries and every state in the union. He is intimately involved in the respiratory management of cardiac by-pass patients on a daily basis.

C. Reliability of Dr. Johnson's Opinions

The Sixth Circuit has confused "reliability" under *Daubert* with credibility issues. The central medical issue in this case is the decision to extubate Sandra on November 11, 1998, and to continue to have her in that condition in the face of her respiratory depression. Dr. Johnson explains that the decision to extubate a patient from a ventilator is an important decision and that if the patient is unable to adequately respirate on their own, then extubation should not occur. This medical analysis is not disputed. The dispute among the experts is whether the clinical picture of Sandra Robinson warranted further ventilation, or whether she should have been extubated. On this question, the experts disagree. Dr. Johnson opined that Michalik and Rosser either ignored the obvious signs that were present in the records, such as the ABGs and the chest x-ray reports, or they failed to take them into account. In either case, it was negligent. The result of this negligence was a catastrophic brain injury for Sandra Robinson.

In *McCullock v. H.B. Fuller Co.*, 61 F.3d 1038 (2d Cir. 1995), the Second Circuit rejected the same type of analysis adopted by the Magistrate in this case. On appeal, Fuller argued that the Plaintiff's experts lacked certain qualifications, and itemized the expert's shortcomings. The Second Circuit found that any dispute as to the experts' lack of specialization, perceived flaws in methodology, or lack of textual authority went to weight and not admissibility. The Court concluded that the defendant's point-by-point, strict scrutiny attack on the experts' qualifications and methodology constituted an unwarranted extension of *Daubert*. "Fuller would have the Trial Judge elevated to the role of St. Peter at the gates of heaven, performing a searching inquiry into the depth of an expert witness's soul – separating the saved from the damned. Such an inquiry would inexorably lead to evaluating witness credibility and weight of the evidence, the ageless role of the jury." *McCullock,* 61 F.3d at 1041.

All of these criticisms cited by either the Magistrate or the Sixth Circuit are directed at Dr. Johnson's credibility. They have no relevance to the issue of "reliability" under FRE 702 and *Daubert*.

CONCLUSION

The Petition for Writ should be granted. This Court should reverse the Sixth Circuit as to the exclusion of Dr. Johnson's testimony and remand the case for trial in the United States District Court for the Eastern District of Tennessee.

Respectfully submitted,

NANCY DICKENSON, CONSERVATOR FOR SANDRA ROBINSON

BY COUNSEL

TIMOTHY W. McAFEE

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 03-5355

[Filed October 25, 2004]

NANCY DICKENSON, Conservator for Sandra Robinson, Plaintiff-Appellant,	)
v.	)
CARDIAC AND THORACIC SURGERY OF EASTERN TENNESSEE, P.C. and ROBERT ROSSER, M.D., Defendants-Appellees.	)

Appeal from the United States District Court
for the Eastern District of Tennessee at Greeneville
No. 00-00405
Dennis H. Inman, Magistrate Judge

Before: KEITH, MOORE, and GILMAN, Circuit Judges.

OPINION

RONALD LEE GILMAN, Circuit Judge. Nancy Dickenson, as the conservator for Sandra Robinson, appeals the grant of summary judgment in favor of Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. (C&T) and Dr. Robert Rosser in this diversity action for medical malpractice. The issue on appeal is whether the district court properly excluded the proffered testimony of Dickenson's medical experts. For the reasons set forth below, we **AFFIRM** the judgment of the district court with respect to C&T, **REVERSE** and **REMAND** for further proceedings with respect to Dr. Rosser, and **VACATE** the order excluding the testimony of Dr. John Penek.

I. BACKGROUND

Robinson underwent heart bypass surgery on November 10, 1998. The surgery was performed by Dr. Richard Michalik, a cardiac surgeon employed by C&T. Dr. Rosser, a pulmonologist, was called upon by Dr. Michalik to provide Robinson with postoperative respiratory care. Following the removal of Robinson's ventilation tube, she suffered brain damage due to insufficient oxygen. The lawsuit brought on Robinson's behalf alleged that her injuries were caused by the purportedly premature removal of her ventilation tube following surgery.

By consent of the parties, the case was assigned to a magistrate judge for disposition. Summary judgment in favor of both defendants was granted on the ground that no witness for Robinson could competently testify concerning the standard of care applicable to either C&T or Dr. Rosser. The plaintiff argues on appeal that the district court erred by not allowing cardiac surgeon W. Dudley Johnson, a practitioner

from Wisconsin, and pulmonologist John Penek, a practitioner from New Jersey, to provide such testimony. This timely appeal followed.

II. ANALYSIS

A. Standard of review

The district court's grant of summary judgment is reviewed de novo. *Therma-Scan, Inc. v. Thermoscan, Inc.*, 295 F.3d 623, 629 (6th Cir. 2002). Summary judgment is proper where there exists no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). In considering a motion for summary judgment, the district court must construe the evidence and draw all reasonable inferences in favor of the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986). The central issue is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986).

Summary judgment was granted in favor of the defendants on the sole ground that the plaintiff failed to present admissible evidence concerning the standard of care applicable to either C&T or Dr. Rosser. *See Rodgers v. Monumental Life Ins. Co.*, 289 F.3d 442, 448 (6th Cir. 2002) ("A complete failure of proof concerning an essential element necessarily renders all other factors immaterial."). Whether the district court's grant of summary judgment was proper consequently turns on the appropriateness of its decision to exclude the testimony of the plaintiff's experts.

B. The district court abused its discretion by excluding the testimony of Dr. Johnson regarding the alleged negligence of Dr. Rosser

Dr. Johnson stated in his affidavit that he is "involved with extubation decisions on almost a daily basis." His curriculum vitae indicates that he has practiced as a cardio-thoracic surgeon since 1965, and that he has performed thousands of heart-related operations. He explained his familiarity with the standard of care for postoperative cardiac patients in Kingsport, Tennessee as follows:

> (1) The published literature that explains the medical community; (2) Published information that describes the community in general; (3) My own knowledge and experience with the type of cardiac surgery being performed and the management of the patient post operatively; (4) Statements of Dr. Rosser and Dr. Michalik contained in their depositions wherein they describe the standard of care; (5) Statements of Dr. Rosser and Dr. Michalik contained in their depositions wherein they describe their educational background and training; and (6) Reviewing the medical records of Sandra Robinson.

Dr. Johnson elaborated on his experience with extubating postoperative patients in his deposition:

> Q. Over the past three years, how many patients have you managed that are on a ventilator that require in, in excess of a three day stay on the ventilator?
>
> A. The majority of my patients.
>
> Q. Okay, how many would that be?

A. Maybe two hundred.

. . .

Q. . . . Do you often request a pulmonary consult for your patients?

A. Very commonly, yes.

Q. Okay. And at what point would you request a pulmonary consult?

A. Sometimes even pre-operatively if they have a long history of lung problems. I'll ask them to see them and follow with us together as we take care of the patients. And commonly afterwards. It could be anywhere. Right away or a day or two later if the patients are still in respiratory difficulty.

Q. Okay. Who would make the decision to extubate a patient?

A. Either can, and we haven't always agreed. And I've cancelled extubations on a number of occasions. And then there has been a rare case where the patient needs to be extubated and I do it. I don't, I mean, it's my patient and I can do whatever I want, but, but I would discuss it with the pulmonary person and we will discuss whether we think the patient is ready to be extubated or not.

. . .

Q. Okay. Just take me through your process of determining . . . whether a patient can be extubated?

A. On my patients it's rather uncommon to extubate them at the day of surgery. Most of them, as I mentioned, are long, difficult cases. I commonly spend ten to fourteen hours in surgery on my patients. There's so much to do with them. Post-operatively, the next day if blood gases are normal, the assist on the respirator is way down, he's moving air in and out well, his lung capacity is, very adequate on how much he can take a deep breath and breathe, he obviously, he or she is alert and neurologically intact. The cardiovascular system would be stable. Normal heart function. Normal blood pressure. Chest x-ray would certainly be satisfactory in terms of no diffuse infiltrates and better than, certainly not worse than what it had been before.

Despite Dr. Johnson's extensive experience, the district court did not allow him to testify regarding the medical services rendered by Dr. Rosser on the ground that Dr. Johnson's testimony was unreliable under the gatekeeping principles set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993), and its progeny. The district court elaborated on its reasons in the following two paragraphs of its opinion:

Dr. Johnson's deposition testimony reveals that he is not competent to testify concerning the standard of care applicable to a pulmonologist at least as concerns extubation of a ventilation tube. Dr. Johnson,

obviously, is a cardiac thoracic surgeon, not a pulmonologist; and he is not trained in pulmonology. He has never qualified as an expert witness in a suit against a pulmonologist. Dr. Johnson's deposition revealed that he knows very little about ventilating medical equipment or the settings to be used. He has never written an article on pulmonology, and could not identify any articles about pulmonology which he has read. Looking to *Daubert*-type issues, there was no peer review regarding his opinion regarding Dr. Rosser's negligence. He could not identify what journals were authoritative that would be applicable to the facts surrounding plaintiff's condition. More importantly, he could not say what journals he read or considered in arriving at his opinion and his methodology. Also, at various points in his testimony he contradicted his affidavit. For example, he stated in his expert report that he examined the plaintiff's chest x-ray in arriving at his opinion. But during the deposition, he testified that he in fact never looked at the plaintiff's x-ray.

In sum, under *Daubert* and its progeny, expert testimony must meet a threshold requirement of reliability. There simply must be more than Dr. Johnson's bare assertion to show that Dr. Rosser deviated from the standard of care in Kingsport, Tennessee. The Court is not saying that a cardiac surgeon can never be a reliable expert when testifying in matters involving pulmonology, or even anesthesiology or some other medical specialty. However, the purported expert must demonstrate a familiarity with accepted medical literature or published standards in these other areas of specialization in order for his testimony to be reliable

> in the sense contemplated by Federal Rule of Evidence 702. For these reasons, the Motion for Summary Judgment of defendant Rosser shall likewise be GRANTED.

The admissibility of expert testimony is governed by Rule 702 of the Federal Rules of Evidence, which provides as follows:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

A district court's exclusion of expert testimony will not be set aside unless we determine that the court abused its discretion. *Gen'l Elec. Co. v. Joiner*, 522 U.S. 136, 143, 118 S. Ct. 512, 139 L. Ed. 2d 508 (1997) ("[T]he question of admissibility of expert testimony is . . . reviewable under the abuse-of-discretion standard."). An abuse of discretion is found where the reviewing court is "firmly convinced that a mistake has been made." *Adcock-Ladd v. Sec'y of Treasury*, 227 F.3d 343, 349 (6th Cir. 2000) (quotation marks omitted) (defining the term "abuse of discretion" to mean that "the lower court relie[d] on clearly erroneous findings of fact, . . . improperly applie[d] the law[,] or use[d] an erroneous legal standard").

The district court appears to have relied most heavily upon its supposition that a "purported expert must demonstrate a familiarity with accepted medical literature or published standards in these other areas of specialization in order for his testimony to be reliable in the sense contemplated by Federal Rule of Evidence 702." This is an erroneous statement of the law. No authority was cited by the district court in support of its above-quoted statement regarding Rule 702, nor have we found any. In fact, "the text of Rule 702 expressly contemplates that an expert may be qualified on the basis of *experience*." Fed. R. Evid. 702 advisory committee's note (2000 Amendments) (emphasis added); *see also Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 156, 143 L. Ed. 2d 238, 119 S. Ct. 1167 (1999) ("[N]o one denies that an expert might draw a conclusion from a set of observations based on extensive and specialized experience."); *Amorgianos v. AMTRAK*, 303 F.3d 256, 267 (2d Cir. 2002) ("Where an expert otherwise reliably utilizes scientific methods to reach a conclusion, lack of textual support may go to the weight, not the admissibility of the expert's testimony.") (quotation marks omitted); *Bonner v. ISP Techs., Inc.*, 259 F.3d 924, 929 (8th Cir. 2001) ("There is no requirement that a medical expert must always cite published studies on general causation in order to reliably conclude that a particular object caused a particular illness.") (quotation marks omitted).

The district court also noted that "Dr. Johnson's deposition revealed that he knows very little about ventilating medical equipment or the setting to be used." Presumably, the district court had in mind the following portion of Dr. Johnson's deposition testimony:

> Q. Okay. What type of ventilator do you use at your hospital?

A. I don't know that. I don't generally run ventilators and adjust them.

Q. Okay, and what mode of ventilation do you use on your patients on average?

A. In terms of . . . ?

Q. In terms of what mode and how that ventilator is getting oxygen to the patient?

A. I don't know the different ventilators that I use.

Q. Okay, well, I mean, are there no general modes of ventilation depending on whether you buy Brand A, Brand B, or Brand C?

A. On the different ventilators, I can't tell you the difference in terms of ventilators.

Q. Well, just tell me in general. What different modes are there to get oxygen to a patient?

A. You just put it in under high pressure. You know, you have volume controls on the ventilators. You have gas control. Percentage of oxygen that you use to ventilate the patients.

Q. What different modes of ventilation are there to get oxygen to a patient?

A. You can intubate them, you can hook it up when they're ventilating that way on the ventilator. You can put a mask over their face. Some kind of, some degree of positive pressure on the mask.

The district court did not explain in its opinion how knowledge of the brand of ventilator used or its settings would affect the reliability of Dr. Johnson's testimony regarding the prematurity of the extubation, which is the issue in this case. Dr. Johnson's testimony regarding the timing of extubation, based on his extensive experience in making those decisions both with and without consultation from a pulmonologist, is not made unreliable by virtue of his inability to recall the mechanical details of the ventilator used in the operation. The timing of extubation is a separate issue from the mechanics of extubation.

As a further reason for its decision, the district court noted that "at various points in his testimony [Dr. Johnson] contradicted his affidavit." The only example offered, however, is that Dr. Johnson "stated in his expert report that he examined the plaintiff's chest x-ray in arriving at his opinion. But during the deposition, he testified that he in fact never looked at the plaintiff's x-ray." This apparent discrepancy is explained by the fact that although Dr. Johnson did not examine the x-ray film itself, he reviewed the radiologist's report, as indicated by the following deposition testimony:

> A. I didn't look at [the x-rays] because, as I've already said, there's staggering reasons not to extubate her, so I didn't need to go look for other reasons . . . .
>
> Q. Okay, so you, you didn't look at the films and consider these films?
>
> A. They were never sent to me.
>
> . . .

Q. But you obviously considered the chest x-rays, did you not?

A. Yeah, the reports.

Q. Okay. Well, what did you learn from the reports?

A. Well, my impression on the reports, it was not a dramatic change. There was something there, but certainly not catastrophic changes on the x-ray.

That Dr. Johnson reviewed the x-ray report rather than the x-ray film itself may go to the weight of his testimony before a jury, but it did not render Dr. Johnson's testimony so unreliable that his testimony should have been excluded altogether.

In sum, *Daubert*'s role of "ensur[ing] that the courtroom door remains closed to junk science,"*Amorgianos v. AMTRAK*, 303 F.3d 256, 267 (2d Cir. 2002), is not served by excluding testimony such as Dr. Johnson's that is supported by extensive relevant experience. Such exclusion is rarely justified in cases involving medical experts as opposed to supposed experts in the area of product liability.*See generally* Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. Health Pol. Pol'y & L. 267 (2001) (characterizing the effect of the *Daubert* and *Kumho Tire* cases on claims of medical expertise as "[m]uch ado about little," while noting that these cases have had a significant effect on toxic tort and products liability litigation). We therefore conclude that the district court abused its discretion by excluding Dr. Johnson's testimony regarding the medical services rendered by Dr. Rosser.

C. The district court did not abuse its discretion by excluding the testimony of Dr. Johnson regarding the alleged negligence of C&T

As the district court noted, "Dr. Johnson professed that he relied upon the deposition testimony of Drs. Michalik and Rosser to underpin his knowledge of the standard of care applicable to cardiac surgeons [such as Dr. Michalik] in Kingsport, Tennessee." Nothing in those depositions, however, supports Dr. Johnson's opinion that the cardiac surgeon is responsible for the pulmonologist's decision of when to extubate a patient. At most, the deposition of Dr. Michalik indicates that the cardiac surgeon often makes the decision to extubate and that frequently such decisions are made collaboratively with a pulmonologist. In this case, however, the uncontroverted evidence establishes that Dr. Michalik called upon Dr. Rosser to "assume that responsibility" and "it was Dr. Rosser who ordered the extubation of the tube."

The lack of support for Dr. Johnson's opinion, coupled with the affidavits of five Kingsport, Tennessee physicians who explained that the practice in Kingsport is that "once a pulmonology consult is obtained, the pulmonologist assumes management of the patient's ventilation and extubation," convinced the district court that Dr. Johnson's opinion on this issue was unreliable. In light of the lack of support for Dr. Johnson's opinion and the contrary evidence found in the affidavits of the local physicians, we conclude that the district court did not abuse its discretion by excluding this testimony. *See Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 152, 119 S. Ct. 1167, 143 L. Ed. 2d 238 (1999) ("[T]he trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable.").

D. The basis for excluding the testimony of Dr. Penek under Rule 37(c) of the Federal Rules of Civil Procedure is no longer pertinent

In a March 5, 2003 order, the trial court excluded the expert testimony of Dr. Penek under Rule 37(c)(1) of the Federal Rules of Civil Procedure. "The Federal Rules of Civil Procedure . . . apply to civil actions in the federal courts, regardless of whether jurisdiction is based on federal question or diversity of citizenship." *Hayes v. Equitable Energy Res. Co.*, 266 F.3d 560, 566 (6th Cir. 2001). Rule 37(c)(1) states as follows:

> A party that without substantial justification fails to disclose information required by Rule 26(a) or 26(e)(1), or to amend a prior response to discovery as required by Rule 26(e)(2), is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed.

We review the exclusion of expert testimony pursuant to Rule 37(c)(1) under an abuse-of-discretion standard. *Jahn v. Equine Servs., PSC*, 233 F.3d 382, 388 (6th Cir. 2000). "[W]here exclusion necessarily entails dismissal of the case, the sanction must be one that a reasonable jurist, apprised of all the circumstances, would have chosen as proportionate to the infraction." *Musser v. Gentiva Health Servs.*, 356 F.3d 751, 756 (7th Cir. 2004) (quotation marks omitted). "The exclusion of non-disclosed evidence is automatic and mandatory under Rule 37(c)(1) unless non-disclosure was justified or harmless." *Id.* at 758.

The district court refused to permit Dr. Penek to testify, explaining as follows:

> Serious prejudice would result if Dr. Penek were allowed to testify now. . . . The Court neither faults nor criticizes the efforts of plaintiff's counsel. But there is no good cause for yet another extension of time against these physicians. In the 1525 days between the plaintiff's injury and the filing of the present Motion [to waive the Tennessee locality rule (T.C.A. § 29-26-115(b)) and permit the testimony of Dr. Penek], the proof, if it exists, could and should have been marshaled. Even though the trial date, which was only two months away when the Motion was filed, has been moved, were the Court to grant the Plaintiff's request it would be the better part of another year for the defendants to finally go to trial. Because the scheduling order must have some meaning, particularly three years into a lawsuit, the Motion is DENIED.

Because a new trial date will be set once this case is remanded to the district court, the district court's conclusion that harm would flow to Dr. Rosser by further delay in the trial date if Dr. Penek were allowed to testify is no longer a consideration. We therefore conclude that the order excluding Dr. Penek's testimony should be vacated.

III. CONCLUSION

For all of the reasons set forth above, we **AFFIRM** the judgment of the district court with respect to C&T, **REVERSE** and **REMAND** for further proceedings with respect to Dr. Rosser, and **VACATE** the order excluding the testimony of Dr. Penek.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE AT GREENEVILLE
No. 2:00-CV-405

[Filed March 5, 2003]

SANDRA ROBINSON,	)
	)
v.	)
	)
CARDIAC AND THORACIC SURGERY OF EASTERN TENNESSEE, P.C., and ROBERT A. ROSSER, M.D.	)
	)

MEMORANDUM REGARDING MOTIONS FOR SUMMARY JUDGMENT

The defendants Robert Rosser ("Rosser") and Cardiac and Thoracic Surgery of Eastern Tennessee ("C & T") have moved for summary judgment.[1] A hearing was held on February 25, 2003.

Summary judgment is proper only if the record reveals that "there is no genuine issue as to any material fact and that

[1] Doc. 197,223.

the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). The non-moving party must be indulged with all possible favorable inferences from the facts. *Plott v. Gen. Motors Corp.*, 71 F.3d 1190 (6th Cir. 1995). Thus, if there are contrary inferences which can be drawn from facts otherwise undisputed, then summary judgment is precluded.

Inasmuch as this is a medical malpractice action, whether there exits contested issues of material facts must be determined in the context of T.C.A. § 29-26-115, Rule 703 of the Federal Rules of Evidence, *Daubert v. Merrell Dow Pharmaceuticals,*[2] and *Kumho Tire Co. v. Carmichael.*[3]

T.C.A. § 29-26-115 requires that a plaintiff in a medical malpractice action prove (1) the standard of professional care attributable to the defendants' medical specialties in the geographical are in which the defendants practice, (2) that the defendants breached such standard(s) of care, and (3) that the plaintiff suffered injuries as a proximate result of that breach. Further, the expert witness must be licensed in Tennessee or one of its eight contiguous states to practice the defendant's specialty.[4] Under *Daubert,* the trial court is to serve as a "gatekeeper" and determine if the proffered testimony of an expert witness is reliable. If it is not, the testimony should not be admitted. And in the case of a medical malpractice action, if the expert testimony is deemed unreliable and therefore not admitted, the suit itself must fail due to the lack of an expert witness as required by T.C.A. § 29-26-115.

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[2] 509 U.S. 579 (1993).

[3] 526 U.S. 137 (1999).

[4] This provision can be waived, as it was waived in this case with respect to Dr. Dudley Johnson, plaintiff's expert witness.

C &T specializes in the practice of cardiac surgery. The only expert medical witness offered by plaintiff to prove the standard of care applicable to this defendant and the breach thereof is the testimony of Dr. Dudley Johnson, a cardiac/thoracic surgeon, who practices in Milwaukee, Wiconsin.

Plaintiff does not claim there her injuries resulted from the cardiac surgery performed on her by Dr. Michalik of C & T. Rather, she claims that her injuries were the direct result of a premature post-surgery extubation of a ventilation tube. After the cardiac surgery, and because plaintiff was manifesting respiratory problems, Dr. Michalik asked that Dr. Rosser, a pulmonologist, participate in plaintiff's post-surgical care with respect to her respiratory condition. It was Dr. Rosser of course who ordered the extubation of the tube. Plaintiff's expert, Dr. Johnson opines that Dr. Michalik, as the operating surgeon, remained responsible to plaintiff regarding her respiratory problems, notwithstanding that he requested that Dr. Rosser, a pulmonologist, assume that responsibility.

Dr. Rosser was not Dr. Michalik's agent; he was an independent contractor in every sense of that term. Thus, Dr. Michalik cannot be vicariously liable for any negligent acts by Dr. Rosser. If Michalik, i.e., C & T, is liable to plaintiff, it must be for some breach of duty directly owing plaintiff by C & T.

Absent a claim that Dr. Rosser was incompetent and Dr. Michalik had actual knowledge that the extubation was contra-indicated, Dr. Michalik reasonably should be allowed to rely on the pulmonologist to perform his job competently. Stated another way, Dr. Michalik should not be charged with the duty of standing over the pulmonologist's and second-

guessing every decision made by him in the realm of the pulmonologist. It is, after all, the area of the pulmonologist's specialty and is not within the expertise of a cardiac surgeon. Dr. Johnson himself acknowledged that he often requests pulmonary consultations in his cases, and only rarely performs an extubation himself.

Dr. Johnson's opinion simply is not reliable to the extent that he maintains that Dr. Michalik should be responsible for the premature extubation - if indeed it was premature - performed by Dr. Rosser. Dr. Johnson professed that he relied upon the deposition testimony of Drs. Michalik and Rosser to underpin his knowledge of the standard of care applicable to cardiac surgeons in Kingsport, Tennessee. However, as evidenced by the affidavits of five physicians who actually practice in the Kingsport area, it is clear that, at least in Kingsport, Tennessee, once a pulmonology consult is obtained, the pulmonologist assumes management of the patient's ventilation and extubation.[5] In short, Dr. Johnson's

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[5] At first blush, it appears that the Court is weighing conflicting evidence - Johnson's opinion versus those of the five Kingsport physicians - which normally the Court may not do while considering a motion for summary judgment. But where the issue is the reliability of expert opinion under *Daubert*, there necessarily is a modicum of "weighing the evidence." In *General Electric Co. v. Joiner*, 522 U.S. 136 (1997), the Supreme Court flatly held that the admissibility of expert testimony is discretionary with the trial judge and is reviewable under the abuse-of-discretion standard. "On a motion for summary judgment, disputed issues of fact are resolved against the moving party....But the question of admissibility of expert testimony is not such an issue of fact, and is reviewable under the abuse-of-discretion standard." *Id.*, at 143. Dr. Johnson's conclusion is founded solely upon his *ipse dixit*. The difference between his conclusions and those of the five local

opinion is not considered reliable in the sense of contemplated by *Daubert* and *Kumo Tire*. Moreover, Dr. Johnson could not cite to any treatise or other learned work to support his opinion. Dr. Johnson's opinion is *ipse dixit*, and nothing more.

Since Dr. Johnson's evidence may not be received to establish that standard of care applicable to C &T or a breach therof, the Motion of Summary Judgment filed by C & T shall be GRANTED.

All that has been said with respect to the lack of reliability of Dr. Johnson's opinions regarding Dr. Michalik applies with equal force to Dr. Rosser. Indeed, his opinion is even less reliable with respect to Dr. Rosser. Dr. Johnson's depostion testimony reveals that he is not competent to testify concerning the standard of care applicable to a pulmonologist at least as concerns extubation of a ventilation tube. Dr. Johnson, obviously, is a cardiac thoracic surgeon, not a pulmonologist; and he is not trained in pulmonology. He has never qualified as an expert witness in a suit against a pulmonologist. Dr. Johnson's deposition revealed that he knows very little about ventilating medical equipment or the setting to be used. He has never written an article on pulmonology, and he could not identify any articles about pulmonoglogy which he has read. Looking to *Daubert*-type issues, there was no peer review regarding his opinion regarding Dr. Rosser's negligence. He could not identify what

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physicians is stark and diametrically opposed. The basis of Dr. Johnson's opinion is, "it is because I say it is," and that simply cannot be determined to be reliable in the face of five local physicians who actually practice medicine in Kingsport, Tennessee, day in and day out.

journals were authoritative that would be applicable to the facts surrounding plaintiff's condition. More importantly, he could not say what journals he read or considered in arriving at his opinion and his methodology. Also, at various points in his testimony he contradicted his affidavit. For example, he stated in his expert report that he examined the plaintiff's chest x-ray in arriving at his opinion. But during the deposition, he testified that he in fact never looked at the plaintiff's x-ray.

In sum, under *Daubert* and its progeny, expert testimony must meet a threshold requirement or reliability. There simply must be more than Dr. Johnson's bare assertion to show that Dr. Rosser deviated from the standard of care in Kingsport, Tennessee. The Court is not saying that a cardiac surgeon can never be a reliable expert when testifying in matters involving pulmonology, or even anesthesiology or some other medical specialty, However, the purported expert must demonstrate a familiarity with accepted medical literature or published standards in these other areas of specialization in order for his testimony to be reliable in the sense contemplated by Federal Rule of Evidence 702. For these reasons, the Motion for Summary Judgment of defendant Rosser shall likewise be GRANTED.

ENTER:

/s/_____
Dennis H. Inman
United States Magistrate Judge

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE AT GREENEVILLE
No. 2:00-CV-405

[Filed March 5, 2003]

SANDRA ROBINSON,	)
	)
v.	)
	)
WELLMONT HEALTH SYSTEMS, INC., ET AL	)
	)

ORDER

Plaintiff has filed a Motion [Doc. 194] to waive the requirements of T.C.A. § 29-26-115(b) in order to permit the testimony in this case of Dr. John Penek, a pulmonologist who practices in the State of New Jersey. Oral argument was held on February 25, 2003.

On November 21, 2000, this action was instituted against a host of hospitals and physicians, including Dr. Robert A. Rosser, a pulmonologist practicing in Kingsport, Tennessee, who treated the plaintiff in November of 1998. All defendants have been voluntarily dismissed by the plaintiff except for Dr.

Rosser and Cardiac and Thoracic Surgery of eastern Tennessee, P.C.[1]

On August 28, 2001, this Court entered its scheduling order. One of the requirements of the scheduling order was that the plaintiff disclose her expert witnesses under F.R.Civ.P.26(a)(2) on or before December 31, 2001. The Court extended the deadline for her expert witness disclosures to January 31, 2002. At that time, she identified Dr. Dudley Johnson, a cardiac and thoracic surgeon from Milwaukee, Wisconsin, and Dr. Steven Koenig, a pulmonologist from Charlottesville, Virginia.[2]

In May of 2002, the plaintiff was advised by Dr. Koenig, literally five minutes before he was to be deposed, that he had changed his mind and no longer felt that Dr. Rosser had deviated from the standard of care for a pulmonologist practicing in Kingsport, Tennessee. At that time, the trial of this case was 10 months away.

In the present motion, the plaintiff recounts the various efforts made to find another pulmonologist, both within the geographic area required by the locality rule and elsewhere. Eventually, this quest led to finding Dr. Penek. On January 14, 2003, the plaintiff filed the present motion. On February 2, 2003, the plaintiff served the required expert report of Dr. Penek on the defendants.

---

[1] An earlier suit had been filed in the Tennessee state courts, but voluntarily dismissed before this action was filed.

[2] The Court found, with respect to Dr. Johnson, that the plaintiff was entitled to a waiver under the statute from the effect of the so called "locality rule."

The Court has previously, when trial was over a year distant, accorded great latitude to the plaintiff in finding physicians to testify in this case. This was done in spite of some misgiving about this being a "lawsuit in search of proof." however, the same fundamental fairness which prompted the Court to extend the plaintiff's disclosure deadline to January 31, 2002, applies equally to the defendants. They were not prejudiced by extending the deadline at that time. However, serious prejudice would result if Dr. Penek were allowed to testify now, assuming that plaintiff could meet her burden regarding yet another waiver of the locality rule. No application for relief was made until 348 days after the original deadline, and 9 months after the plaintiff know that Dr. Koenig would no longer support her position. The 26(a)(2) disclosure was not made until nearly 3 weeks after that.

The Court neither faults nor criticizes the efforts of plaintiff's counsel. But there is no good cause for yet another extension of time against these physicians. In the 1525 days between the plaintiff's injury and the filing of the present Motion, the proof, if it exists, could and should have been marshaled. Even though the trial date, which was only two months away when the Motion was filed, has been moved, were the Court to grant the plaintiff's request it would be the better part of another year for the defendants to finally go to trial. Because the scheduling order must have some meaning, particularly nearly three years into a lawsuit, the Motion is DENIED.

SO ORDERED:

/s/_____

Dennis H. Inman
United States Magistrate Judge

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE AT GREENEVILLE
No. 2:00-CV-405

[Filed March 5, 2003]

SANDRA ROBINSON,	)
	)
v.	)
	)
WELLMONT HEALTH SYSTEMS, INC., ET AL	)
	)

ORDER

For the reasons set forth in the Court's order denying plaintiff's motion to waive the locality rule with respect to Dr. Jon Penek, the Cross-Motion [Doc.211] of Dr. Robert A. Rosser to exclude Dr. Penek's testimony is GRANTED.

SO ORDERED:
/s/_____

Dennis H. Inman
United States Magistrate Judge

(2)

FILED
MAR 4 - 2005

No. 04-1005

IN THE

Supreme Court of the United States

NANCY DICKENSON, CONSERVATOR FOR SANDRA ROBINSON,

Petitioner,

v.

CARDIAC AND THORACIC SURGERY OF EASTERN TENNESSEE, P.C.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

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STATEMENT OF THE ISSUE PRESENTED FOR REVIEW

This defendant does not agree with the statement of issues presented for review by the petitioner with regard to the admission of Dr. Johnson's testimony. Instead, this defendant says that the Statement of Issues presented for review with regard to the opinion of Dr. W. Dudley Johnson is as follows:

Did the Sixth Circuit err in finding that the Magistrate did not abuse his discretion under the principles of the Federal Rule of Evidence 702, *Daubert v. Merrell Dow Pharmaceuticals,* 509 U.S. 679 (1993), *Kumho Tire Co. v. Carmichael,* 526 U.S. 137 (1999), and *General Electric Co. v. Joiner*, 522 U.S. 136 (1997) when it declared the testimony of plaintiff's expert Dr. W. Dudley Johnson to be unreliable?

CORPORATE DISCLOSURE STATEMENT

Respondent, Cardiac and Thoracic Surgery of Eastern Tennessee, P.C., has no parent corporation and no publicly held company owns 10% or more of its stock.

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Fed. R. Evid. 702 ..... i, 1, 12

STANDARD OF REVIEW

The question of admissibility of expert testimony is not an issue of fact such as presented on Motion for Summary Judgment but is reviewable under the abuse of discretion standard.

STATEMENT OF THE CASE

This is a medical malpractice case and as such the contested issue of material fact is the standard of care which must be determined in the context of T.C.A. § 29-26-115 and Rule 702 of the Federal Rules of Evidence. Evidence must also pass muster of the trial court in determining its reliability under the *Daubert* rule. The issues in this case require review of the evidence with regard to the reliability of testimony by the plaintiff's primary witness, Dr. W. Dudley Johnson, and the reasons why the trial court found his proffered testimony to be unreliable and therefore refused to allow it.

The Court of Appeals affirmed this action on the part of the District Court.

Sandra Robinson came under the care of Dr. Richard Michalik, a cardiac surgeon, at Holston Valley Medical Center in Kingsport, Tennessee on November 10, 1998. Dr. Michalik is an employee of Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. Dr. Michalik performed a myocardial revascularization procedure under general anesthesia on plaintiff. This procedure is also known as a coronary artery bypass graft. During that procedure the anesthesiologist noted wheezing with respect to the patient's breath sounds, and based on this as well as Ms. Robinson's previous medical

history and physical condition immediately post-operatively, it was Dr. Michalik's opinion that a pulmonary consult was appropriate. He ordered consultation with Dr. Robert Rosser, a pulmonologist, who ordered a trial of CPAP followed by blood gases tests. Dr. Rosser, subsequently without the participation of Dr. Michalik, ordered the extubation of Ms. Robinson.

Dr. Michalik says that when he obtained a pulmonary consult from Dr. Rosser the standard of care in Kingsport with regard to a post-operative patients such as Ms. Robinson in November, 1998, provided that Dr. Rosser would take over the pulmonary responsibility for Ms. Robinson. Dr. Michalik says that he had the right to rely on the expertise of Dr. Rosser with respect to her pulmonary care and he did so, and Dr. Rosser's subsequent intubation of Ms. Robinson was appropriate and met the standard of care in Kingsport, Tennessee with regard to respiratory management. Dr. Michalik also explained that one of the compelling reasons that pulmonologists are to assume management of any ventilator or pulmonary therapies after consultation is that such management provides the patient with continual access to board certified pulmonologists who can be readily accessed or on the scene and who are knowledgeable of such patients instead of relying on the cardiac surgeons who may be relatively inaccessible because of extended obligations in the operating room. Another reason, according to Dr. Michalik, is that a consulting pulmonologist is more highly trained in pulmonary care and management than a cardiac surgeon.

Therefore the standard of care, according to Dr. Michalik, in Kingsport, Tennessee, is predicated on the belief that other patients' variables notwithstanding best management of the

pulmonary status in difficult or complex patients such as Ms. Robinson is provided by certified pulmonologists such as Dr. Rosser.

Dr. Rosser also testified in his deposition that after consultation he was responsible for the primary respiratory management of the patient. Dr. Rosser said that he had no recollection of any circumstance in which he had not been the decision maker with respect to extubation, and that he would not, as a routine, call Dr. Michalik to discuss extubation. He said that he had provided pulmonary consultation on cardiac patients operated on by Dr. Michalik on many occasions prior to November, 1998, when he treated Mrs. Robinson. Dr. Rosser said "that there may be a hundred or more." (R. 223, Brief in Support of Motion for Summary Judgment, deposition of Dr. Rosser, Collective Ex. 11, JA pp. 1309 - 1313).

The only witness offered by the plaintiff to contradict the standard of care in Kingsport, Tennessee, as defined by Dr. Michalik and Dr. Rosser was Dr. W. Dudley Johnson, a cardiac surgeon in Milwaukee, Wisconsin. Dr. Johnson filed a report regarding his opinions concerning the plaintiff Sandra Robinson. In his report Dr. Johnson noted that there is a "TO" (telephone order) from *Dr. Rosser to extubate the patient on the morning of November 11th.* Dr. Johnson is of the opinion that the patient was under-ventilated at this time and says that the patient "should not have been extubated in this condition. It is a deviation in the standard of care for the patient to be extubated at this time. *Both Dr. Michalik and Dr. Rosser* are negligent." (R. 223, Brief, Report of Dr. W. Dudley Johnson, Ex. 3; JA pp. 1330 - 1342).

In an Affidavit filed in response to this defendant's Motion in Limine and Motion for Summary Judgment Dr. Johnson attempted to demonstrate the source of his alleged claim of familiarity with the standard of care in Kingsport, Tennessee. As one of his sources of claimed knowledge Dr. Johnson referred to "*statements of Dr. Rosser and Dr. Michalik contained in their depositions wherein they described the standard of care; statements of Dr. Rosser and Dr. Michalik contained in their depositions wherein they described their educational backgrounds and training.*" [emphasis supplied]. He also stated that in Kingsport, Tennessee "[W]hen a consultation is requested, like what occurred in this case, then both the cardiac surgeon and pulmonologist share in the respiratory management of the patient." Dr. Johnson said the decision to extubate a patient following by-pass surgery is an important part of the respiratory management and in this case, and he claimed Dr. Richard Michalik and Dr. Rosser are "both responsible to make the correct decision." (R. 223, Brief, Report of Dr. W. Dudley Johnson, Exhibit 3; JA pp. 1330 -1342).

In addition, Dr. Johnson claimed that "primarily the cardiac surgeon was responsible to see that the patient receives appropriate pulmonary management post-operatively. However, he/she may request consultation from the pulmonologist." Further, with regard to the standard of care he said that "there is no difference in the standard of care for the treatment of Sandra Robinson by a board certified medical doctor or by someone who is practicing in the fields of cardiac surgery and pulmonology, or intensive care nursing and medicine." (R. 223, Brief, Report of Dr. W. Dudley Johnson, Exhibit 3; JA pp. 1330 - 1342).

Dr. Johnson went on to state that the standard of care for a board certified physician in Kingsport, Tennessee is the same as a board certified physician in any state.

Dr. Johnson in his Affidavit claims Dr. Michalik stated in his deposition that the decision to extubate a patient is a collaborative effort. This is *not* a correct rendering of Dr. Michalik's testimony. Dr. Michalik said that his responsibility was to see that the patient receive the best possible pulmonary care, and that this is the reason that he would refer a patient to a pulmonologist.

Dr. Johnson makes the unequivocal statement in his Affidavit that "I have read the questions and answers of Dr. Rosser and Dr. Michalik during their deposition as they pertain to the standard of care." (R. 206, Response of Plaintiff, Affidavit of W. Dudley Johnson; JA pp. 903 - 909). He also makes the flat statement that "*the standard of care in Milwaukee, Wisconsin would be identical* (emphasis supplied) to the explanation given by Dr. Rosser and Dr. Michalik." (R. 206, Response of Plaintiff, Affidavit of W. Dudley Johnson; JA pp. 903 - 909). In short, the plaintiff's expert witness is adopting the testimony of Dr. Michalik and Dr. Rosser to support his claim that the standard of care is the same in Milwaukee as that standard set forth by Dr. Rosser and Dr. Michalik in their depositions and affidavits. *Such testimony by Dr. Michalik and Dr. Rosser however establishes a standard of care entirely different from that proclaimed by Dr. Johnson.*

Dr. Michalik testified in his deposition with regard to the standard of care as follows:

Q. Well, explain, in as much detail as you wish, what the standard of care would require for a cardiac surgeon post-operatively on a patient that has the pulmonary history you've given for Ms. Robinson.

A. *The standard of care would be once that you recognize that you do indeed have a pulmonary patient that has some difficulty, some risk factors that are coming into play, to make sure that she gets the best possible pulmonary care.*

Q. *Now, I that – when the patient is to get the best possible pulmonary care, is it at the hand of the cardiac surgeon, at the hands of the pulmonologist or both?* (emphasis supplied).

A. The pulmonary care, specifically?

Q. Yes, Sir. I'm talking about the pulmonary care, specifically, yes.

A. *It would be the pulmonologist. That's why I ask them to do that.* (emphasis supplied).

Q. All right.

A. *They do not operate in a vacuum, but the pulmonary care is their province.* (emphasis supplied)

(R. 223, Brief in Support of Motion for Summary Judgment, deposition of Dr. Michalik, Collective Ex. 10, pp. 30 and 31 JA pp. 1307 - 1308).

Dr. Rosser also testified in his deposition as follows:

Q. Well, I guess more specifically I'm asking how did the two of you provide respiratory management to the patients post-operatively? For example, was it all left up to you? Was it a joint decision that you all would talk about jointly? Did he listen to you and say, "Oh, I'm going to do my own thing anyway"? I mean, give me what habit, if any, there was between you, or routine between you and Dr. Michalik with respect to how the two of you managed patients respiratory wise, post-operatively?

A. I would make the changes. If I had concerns, I might talk with him about my concerns.

Q. Well, between the two of you, who provided the respiratory management of the patients?

A. *I would be providing the primary management.*

Q. Okay. And when you say "primary", would he be secondary or there would be other secondary?

A. As I alluded to earlier, in the circumstances of an emergent situation, some problem, and if he were present and I was not, and I have no recollection of a specific incidence in which that was done, but that would be what I

would anticipate. I would anticipate that he would respond appropriately until I or my representative did respond.

Q. For example, the decision to extubate a patient, when you have been consulted by Dr. Michalik in the past, have you always been the *decision maker with respect to extubation*? (emphasis supplied).

A. *Always is a difficult word. I have no recollection of any circumstance in which I was not.* (emphasis supplied).

Q. Would you – was it your practice to discuss with Dr. Michalik that decision process as a courtesy or for input from Dr. Michalik?

A. I wouldn't, as a routine, call him to discuss extubation.

Q. What type of circumstance would cause you to talk with him about extubation or circumstances?

A. You know, it would be numerous potential categories, if she might need another procedure. I said she, the individual might need another procedure. If there was some element of her care that I thought was outside my (inaudible – loud cough), if you will, I might see if my extubation of the patient would impact what else they were doing, that sort of thing, I mean, there's many potential reasons why I might.

Q. With respect to Sandra Robinson, did you become involved with her care on November the 10th . . . .

A. Yes.

Q. . . . . 1998? And was that because Dr. Michalik had requested a consultation from you?

A. Yes.

Q. Do you recall how you were notified of his request for consultation?

A. Yes. He called me.

(R. 223, Brief in Support of Motion for Summary Judgment, deposition of Dr. Rosser, Collective Ex. 11, pp. 27, 28, 29, 30; JA pp. 1310 - 1313).

Further, Dr. Johnson has not indicated how the Kingsport medical community was similar to, and thus had the same standard of professional care as the community with which he was familiar. In his report he simply make the conclusory statement that the facts surrounding the health care in Kingsport, Tennessee was "substantially similar to the medical community in which he practices and has practiced for a number of years."

The defendant Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. also submitted to the court the following Affidavits which established that the standard of care is other than that claimed by Dr. Johnson.

1. Dr. David E. Sewell, founder of Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. stated that under the orders issued by Dr. Michalik, which were for pulmonary medical consult, that pulmonary medicine assumed management of the plaintiff's ventilation and extubation and that Dr. Michalik had transferred the pulmonary care to Dr. Rosser according to the standard of care practice in Kingsport.

2. Dr. Ken W. Smith, neurosurgeon practicing in Kingsport, Tennessee, is familiar with the standard of care of physicians who treat patients post-operatively for conditions such as cardiac surgery as performed on Sandra Robinson. Dr. Smith is of the opinion that the standard of care in Kingsport is that when a pulmonologist is called to consult on a heart patient or other surgery patient that the pulmonologist is responsible for the respiratory management of the patient as long as he or she stays on the case of that patient, and the cardiac surgeon has a right under the standard of care in Kingsport to rely on the pulmonologist for the respiratory management of the patient.

3. Dr. Richard Feit, who is a member of the Cardiac and Thoracic Surgery of Eastern Tennessee, P.C. has practiced cardiac surgery in Kingsport, Tennessee since 1982. He is of the opinion that the pulmonologist, under the standard of care in Kingsport, Tennessee, is in charge of ventilatory management of the patient and the cardiac surgeon has a right to rely on decisions of the pulmonologist with relation to the extubation and intubation of the patient.

4. Dr. Robert McKay, a board certified anesthesiologist in neighboring Bristol, Tennessee states his opinion as follows:

> In my opinion Dr. Michalik did not deviate from the standard of care for a physician providing postoperative respiratory care to a patient in the intensive care unit following cardiac surgery in Kingsport, Tennessee in November, 1998. He very appropriately obtained a postoperative pulmonary medicine consult on Mrs. Robinson. The combination of morbid obesity, tobacco abuse, high levels of anxiety, and the observation of intra-operative wheezing and rhonchi made the consultation prudent. Once this consultation was made, Dr. Michalik was entitled to rely on Dr. Rosser and the pulmonary medical service for the respiratory care of his postoperative patient.

(R. 223, Brief, Affidavit of Dr. Robert McKay, Ex. 8; JA pp. 1275 - 1303).

REASONS FOR DENYING THE PETITION

The petitioner in this case in asserting her claim for medical malpractice must prove the standard of care applicable to the defendant's medical specialties in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred, and that the defendant breached such standard of care and the plaintiff sustained injuries as an approximate result of the breach. See T.C.A. § 29-26-115.

In *Legg v. Chopra*, 265 F.3d 286 (6th Cir. 2002) the court held that even if a witness is deemed competent to testify to the substantive issue in the case such as the standard of care,

this in and of itself does not completely fulfill the requirements for admissibility. The expert testimony should then be screened under Rule 702 to determine if it is otherwise admissible. The court in *Legg* went on to hold that there was no conflict between T.C.A. § 29-26-115 and FED. R. EVID. 702, since the first is directed toward establishing the substantive issue in the case and the second is a gatekeeping measure designed to insure "fairness in administration" of the case.

Under *Kumho Tire Company, Ltd. v. Carmichael,* 526 U.S. 137, 119 S.Ct. 1167, the court established that the "*Daubert* 'gatekeeping' obligation" applies not only to scientific testimony but to all expert testimony and the objective of *Daubert's* "gatekeeping" requirement is to make certain that an expert employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.

The trial court in this case stated in its Memorandum Opinion that "under *Daubert* the trial court is to serve as the gatekeeper and determine if the proffered testimony of an expert is reliable. If it is not, the testimony should not be admitted."

In determining whether or not Dr. Johnson's testimony was reliable the court had the following facts before it:

Dr. Johnson proclaimed that he was familiar with the standard of care in Kingsport, Tennessee, and one of the reasons for this familiarity was the statements of Dr. Rosser and Dr. Michalik contained in their depositions wherein they described the standard of care.

Both Dr. Rosser and Dr. Michalik stated that the standard of care in Kingsport, Tennessee was that after a pulmonary consult was obtained in a post-operative patient such as Ms. Robinson, *the pulmonary physician took over the pulmonary responsibility for the patient.* This lends no support to the claim of Dr. W. Dudley Johnson that when a consultation is requested that both the cardiac surgeon and the pulmonologist share in the respiratory management of the patient. Dr. Johnson also made the statement in his affidavit that he had read the questions and answers of Dr. Rosser and Dr. Michalik during their depositions as they pertain to the standard of care, but he ignored the standard of care clearly explained by these two physicians that the standard of care required responsibility for pulmonary care to be that of the pulmonologist when consultation is made. Dr. Johnson testified "the standard of care in Milwaukee, Wisconsin, would be identical to the explanation given by Dr. Rosser and Dr. Michalik". Given this statement, then the plaintiff's expert is adopting the standard of care stated by Dr. Rosser and Dr. Michalik and he should not be heard to claim the contrary. Furthermore, Dr. Johnson went on to claim that the standard of care in Kingsport, Tennessee, is the same as a board certified physician in any state. This is based upon a national standard and such evidence may not substitute for evidence that first establishes the requirements of T.C.A. § 29-26-115. See *Robinson v. LeCorps*, 83 S.W.3d 718 (Tenn. 2002).

Also, Dr. Johnson goes on to make the statement that "there is no difference in the standard of care for the treatment of Sandra Robinson by a board certified medical doctor or by someone who is practicing in the fields of cardiac surgery and pulmonology, or intensive care nursing and medicine." This statement again exhibits a total lack of understanding

of the standard of care which he says is the same in both Kingsport, Tennessee and Milwaukee, Wisconsin based upon the statements of Dr. Rosser and Dr. Michalik.

Dr. Johnson's claimed reliance on the statements of Dr. Rosser and Dr. Michalik demonstrate that he, Dr. Johnson, simply ignored the statements of these physicians as to the standard of care because the statements made by these physicians show, without question, that Dr. Johnson's standard of care definition for Kingsport, Tennessee, is completely and wholly in error and absolutely contrary to the testimony of Dr. Rosser and Dr. Michalik that he adopted, advocated and supported as setting forth the same standard of care that exists in Milwaukee. The statements made in the report and affidavit of Dr. Johnson absolutely demonstrate the lack of trustworthiness of such testimony. The proclaimed reliance on the standard of care stated by Dr. Michalik and Dr. Rosser, which is quite clearly contrary to the opinions advanced by Dr. Johnson renders his opinions totally unreliable. This was recognized and declared to be so by the District Court. In its Memorandum Opinion the District Court stated as follows:

> Absent a claim that Dr. Rosser was incompetent and Dr. Michalik knew or should have known that he was incompetent, or absent a claim that Dr. Michalik had actual knowledge that the extubation was contra-indicated, Dr. Michalik reasonably should be allowed to rely on the pulmonologist to perform his job competently. Stated another way, Dr. Michalik should not be charged with the duty of standing over the pulmonologist and second-guessing every decision made by him in the realm of the

> pulmonologist's responsibility. Otherwise, there would be little reason to request the services of a pulmonologist. It is, after all, the area of the pulmonologist's specialty and is not within the expertise of a cardiac surgeon. Dr. Johnson himself acknowledged that he often requests pulmonary consultations in his cases, and only rarely performs an extubation himself.
>
> Dr. Johnson's opinion simply is not reliable to the extent that he maintains that Dr. Michalik should be responsible for the premature extubation - if indeed it was premature performed by Dr. Rosser. Dr. Johnson professed that he relied upon the deposition testimony of Drs. Michalik and Rosser to underpin his knowledge of the standard of care applicable to cardiac surgeons in Kingsport, Tennessee. However, as evidenced by the affidavits of five physicians who actually practice in the Kingsport area, it is clear that, at least in Kingsport, Tennessee, once a pulmonology consult is obtained, the pulmonologist assumes management of the patient's ventilation and extubation. In short, Dr. Johnson's opinion is not considered reliable in the sense contemplated by *Daubert and Kumho Tire.* Moreover, Dr. Johnson could not cite to any treatise or other learned work to support his opinion. Dr. Johnson's opinion is *ipse dixit,* and nothing more.

(*See* Appendix B, page 16(a)).

The Court relied on the holding of *General Electric Company v. Joiner*, 522 U.S. 136 (1997) wherein the Supreme

Court held that the admissibility of expert testimony is discretionary with the trial judge and reviewable under the abuse of discretion standard: *"[O]n a motion for summary judgment, disputed issues of fact are resolved against the moving party . . . . But the question of admissibility of expert testimony is not such an issue of fact, and is reviewable under the abuse-of-discretion standard.*" The District Court below specifically acknowledged in a footnote to its Memorandum Opinion that:

> At first blush, it appears that the Court is weighing conflicting evidence - Johnson's opinion versus those of the five Kingsport physicians - which normally the Court may not do while considering a motion for *summary* judgment. [sic] But where the issue is the reliability of expert opinion under *Daubert,* there necessarily is a modicum of "weighing the evidence. " *In General Electric Co. v. Joiner,* 522 U. S. 136 (1997), the Supreme Court flatly held that the admissibility of expert testimony is discretionary with the trial judge and is reviewable under the abuse-of-discretion standard: "On a motion for summary judgment, disputed issues of fact are resolved against the moving party .... But the question of admissibility of expert testimony is not such an issue of fact, and is reviewable under the abuse-of-discretion standard. *Id.,* at 143. Dr. Johnson's conclusion is founded solely upon his *ipse dixit.* The difference between his conclusions and those of the five local physicians is stark and diametrically opposed. The basis of Dr. Johnson's opinion is, "it is because I say it is," and that simply cannot be determined to be reliable in the

> face of five local physicians who actually practice medicine in Kingsport, Tennessee, day in and day out.

(*See* Appendix B, page 19(a)).

In holding that the District Court did not abuse its discretion by excluding the testimony of Dr. Johnson regarding the alleged negligence of Cardiac and Thoracic Surgery the Sixth Circuit stated as follows:

> As the district court noted, "Dr. Johnson professed that he relied upon the deposition testimony of Drs. Michalik and Rosser to underpin his knowledge of the standard of care applicable to cardiac surgeons [such as Dr. Michalik] in Kingsport, Tennessee." Nothing in those depositions, however, supports Dr. Johnson's opinion that the cardiac surgeon is responsible for the pulmonologist's decision of when to extubate a patient. At the most, the deposition of Dr. Michalik indicates that the cardiac surgeon often makes the decision to extubate and that frequently such decisions are made collaboratively with a pulmonologist. In this case, however, the uncontroverted evidence establishes that Dr. Michalik called upon Dr. Rosser to "assume that responsibility" and "it was Dr. Rosser who ordered the extubation of the tube." The lack of support for Dr. Johnson's opinion, coupled with the affidavits of five Kingsport, Tennessee physicians who explained that the practice in Kingsport is that "once a pulmonology consult is obtained, the pulmonologist assumes management of the

> patient's ventilation and extubation," convinced the district court that Dr. Johnson's opinion on this issue was unreliable. In light of the lack of support for Dr. Johnson's opinion and the contrary evidence found in the affidavits of the local physicians, we conclude that the district court did not abuse its discretion by excluding this testimony. *See Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 152, 143, L. Ed. 2d 238, 119 S. Ct. 1167 (1999) ("The trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable.").

(*See* Appendix A, page 13(a)).

CONCLUSION

It is respectfully submitted that the Petition for Writ of Certiorari should be denied. The Sixth Circuit correctly held that the District Court did not abuse its discretion in disallowing Dr. Johnson's testimony, that testimony being patently unreliable and simply *ipse dixit* on the part of Dr. Johnson.

Respectfully submitted,

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